Medical School Hotline

The Role of Geriatrics and Gero-Psychiatry in Medical Education

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Is America prepared to face the increasing demands of an aging society?

The average life expectancy for an American female is currently 79 years and 72 years for males. This translates to an estimated 34,991,753 or 12% of the U.S. population over the age of 65.[1] Estimates demonstrate an 82% growth in this group over the past 30 years. The oldest old—persons age 85 and older—comprise the fastest growing segment of the US population.[2] The centenarians who 20 years ago represented less than 100,000 individuals are projected to reach 250,000 by the year 2020. The ever increasing number of individuals aging within American society brings escalating demands on the medical community. These demands extend not only to the primary care physician, but also to the medical and surgical specialties. These clinicians require the skills and medical knowledge necessary to meet the physical, mental, and psychosocial needs of this population.

Medical students, residents, and attending physicians of every field of medicine increasingly encounter the elder population in a variety of clinical settings. Ten years from now, most doctors will spend at least one-half of their clinical time caring for older patients.[3] This influx of aging patients presents physicians and physicians-in-training with a unique responsibility for developing the skills necessary to provide acute and long-term care to this population. Medical education in an effort to address this issue has joined hands with the fields of medicine most attuned to caring for the elder population—geriatric medicine and gero-psychiatry.

The geriatric population, those age 65 and older, encompasses a heterogeneous group of individuals ranging in spectrum from the healthy to frail elder. The complexity and variety of conditions ubiquitous to this population encompasses issues such as depression, dementia, urinary incontinence, sexual impotency, delirium, malnutrition, poly-pharmacy, end-of-life issues, etc. Several geriatric syndromes present with unique psychiatric components, for example a 75-year-old male with Alzheimer's dementia refusing to take medication because he believes his wife is poisoning him or a 68-year-old female 7 months status-post right parietal infarct with left hemi-paresis has increasing insomnia, anhedonia, and weight loss for 3 months. The variability of presentations of these conditions in this group adds to the complexity of diagnosis and management of these disease processes. Many of the syndromes common within the geriatric population result in a progressive decline in physical and cognitive function. The result is an increased dependence upon caregivers (family, friends, paid aides) to provide assistance in daily care. The subsequent realization is that the care of the patient does not end with the patient, but often extends to their caregivers and care-managers. These individuals are of key importance in treatment of the patient, in particular those with dementia. Close attention to the delicate balance between disease, function and health is of crucial importance to any health professional caring for the elderly. Recognition of all these factors is of paramount importance to the clinician providing care for the geriatric population. Hence aggressive training in geriatric medicine and issues unique to this population at all levels of medical training is a necessity.

The overlap between medicine and psychiatry in the geriatric population is evident in almost every conceivable treatment setting. Geriatric medicine and psychiatry interface on a daily basis. This is evident from the outpatient clinic where an elderly patient with multiple medical problems necessitates numerous prescription medications that may induce or exacerbate psychiatric symptoms to the inpatient treatment setting where post-operative and medical illness-induced delirium are commonplace. The elderly also challenge physicians in non-traditional arenas of medicine. Physicians are faced with dealing with end-of-life issues, bereavement over the loss of adult children or a lifetime partner, competency to make financial and medical decisions, and even capacity to drive an automobile. Such broad scope of physician responsibility dictates that training in geriatric psychiatry, with its exposure to psychosocial issues, be included in the training of future physicians.

Recognizing the growing demands of the aging population, the Accreditation Council for Graduate Medical Education (ACGME) has specified requirements for exposure to geriatric clinical experiences in medicine and psychiatry.[4] Internal Medicine requires geriatric clinical exposures and formal instruction for an unspecified length of time. The University of Hawai'i Integrated Residency Program fulfills this requirement with a one-month rotation in a multitude of settings. These settings include multidisciplinary clinics in the Veteran's Administration and local community, inpatient and outpatient consultations, end-of-life care, and nursing home experiences. The ACGME recently implemented a minimum of one month full-time equivalent training in geriatric psychiatry for general psychiatry residents entering residency after 2001. This, in fact, may be insufficient exposure. A 1999 review of the geriatric curriculum development in general psychiatry residency training by Kennedy et al[5] recommended that at least three months training or 7% of the four year residency be dedicated to geriatrics. University of Hawai'i psychiatry residents currently devote one afternoon per week on their Consultation-Liaison rotation to reviewing geriatric consults in conjunction with the Geriatric Medicine team. They also gain exposure during their longitudinal outpatient clinic as well as on the inpatient unit at QMC where an estimated 20% of the total inpatient psychiatry population is over age 65.[6]

Meeting the call to improve training in the care of the elder population requires an innovative approach utilizing a variety of teaching methods that extend beyond the lecture hall. Supported by

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in the past. He used to be a patient of mine, but had transferred to another physician in town.

I recently encountered him in the lobby of our hospital. We started an animated and friendly conversation . The conversation was coming to a natural end when Mr. N turned to me and said,

"Doc, I may need to come and visit you again."

"Why is that?" I inquired. "You know those pills to get it up? My doctor will not give me any of them!"

Surprising even myself, I managed to come back with this quick quip: "Mr. N, in my opinion, your doctor is right. You're a big enough prick as it is." Mr. N was unable to keep a straight face after that.

Dr. Edward Najgebauer, Ontario

The Butterfly: My mother-in-law Bonnie, suffered an ankle fracture and had an appointment to see the local orthopod whose second language was English.

As he entered the room, he was carrying a model of the human pelvis (an instructional aid for a later presentation to students) which he sat down on a table. My mother-in-law who didn't have a clue what it was, felt it resembled a butterfly.

After examining Bonnie's leg, he pronounced all was well and started for the door, forgetting the model pelvis.

Bonnie reminded him, "Excuse me Doctor, you forgot your butterfly".

The venerable orthopod reached for his zipper, pulled it up firmly, stiffly thanked my mother-in-law and strode out the door.

Dr. George Burden

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the Donald J. Reynolds grant in medical education, the Department of Geriatrics at the John A. Burns School of Medicine will strengthen the geriatric curriculum within all medical departments and institutions, thus improving the educational experience for both students and residents. With the combined resources of the Departments of Geriatrics and Psychiatry, innovative curricula utilizing problem-based learning, standardized patients, geriatric outpatient/inpatient consultation teams, outpatient consultation clinics, and geriatric/geropsychiatry inpatient rounds will coalesce to provide a rich educational environment that will lead to improved multidisciplinary care of the elderly in Hawaii.

References

1. US Census demographic data on aging of the U.S. based on 1990-2000 results.
2. Rowe, JW, Kahn RL. Successful Aging, New York: Pantheon Books, 1998.
3. Butler, RN. Wanted: Teachers of Geriatrics: A National Initiative is Needed to train all Doctors in the Care of Older Patients. Geriatrics 55: (12) 11-15; December 2000.
4. Graduate Medical Education Directory. American Medical Association, 2001.
5. Kennedy, GJ et al. Evolution of the geriatric curriculum in general residency training: recommendations for the coming decade. Academic Psychiatry 23: 187-187; 1999.
6. Ahmed, I. Integrating geriatric training in general psychiatry residency program – the Hawaii experience. Presentation to the AAGP Teaching and Training Committee, Fall 2000.

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